CHAPTER II

PROVIDER PARTICIPATION REQUIREMENTS

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PARTICIPATING PRIVATE DUTY NURSING SERVICE PROVIDERS

The Department of Medical Assistance Services (DMAS) reimburses for private duty nursing rendered to individuals authorized for the service through the technology assisted waiver and the Early Periodic Screening, Diagnosis, and Treatment (EPSDT) private duty nursing program. A participating provider for private duty nursing services must be licensed or certified as a Home Health agency by the Virginia Department of Health (VDH) for Medicare/Medicaid participation, must meet any additional standards and requirements set forth by DMAS, and must have a current, signed agreement with DMAS to provide private duty nursing services. (See "Exhibits" at the end of this chapter for a sample of this form.)

PRIVATE DUTY NURSING AGENCIES

Private duty nursing is defined as either continuous nursing provided as primary care for an individual or respite care nursing services designed to relieve the primary caregiver. Private duty nursing agencies provide professional nursing services to individuals in a home- or community-based setting in lieu of institutional care. DMAS must preauthorize Medicaid payment for private duty nursing for individuals who have been assessed and determined to require in-home nursing in order to safely remain in the home. Nurses employed by the private duty nursing agency will administer medications, treatments, and care according to a preauthorized plan of care which specifies the amount and type of care to be rendered. Private duty nursing must be provided by a registered nurse (RN) or licensed practical nurse (LPN) employed by a DMAS-approved private duty nursing provider. The policies in this manual apply to both continuous private duty nursing and respite care when provided by nurses through a private duty nursing agency. Chapter IV of this manual contains a definition of both services.

REQUESTS FOR PROVIDER PARTICIPATION

To become a Medicaid provider of services, providers must obtain separate provider identification numbers for each physical or servicing location wanting to offer services to Virginia Medicaid recipients. The provider must request the participation agreement(s) by writing, telephoning, or faxing their requests to:

First Health
VMAP-PEU
PO Box 26803
Richmond, Virginia 23261-6803

804-270-5105 or 1-888-829-5373 (in state toll-free), fax – 804-270-7027

Requests will be screened to determine whether the applicant meets the basic requirements for participation (e.g., Medicare/Medicaid Home Health Certification and adequacy and experience of staff).

An application for private duty nursing provider status and information regarding provider participation requirements and standards will be mailed to any interested party who requests information or an application to become a Medicaid-approved provider for private duty nursing and who meets the basic requirements for participation. A copy of this application is included in "Exhibits" at the end of this chapter.

DMAS contracts with FIRST HEALTH/Provider Enrollment Unit (FH/PEU) to perform provider enrollment duties. Once FH/PEU receives and reviews an application and determines that the provider meets all the requirements for Medicaid private duty nursing provider participation, FH/PEU will send the provider a copy of the agreement for review and signature. The provider agreement must be returned to FH/PEU with an original signature of the provider's administrative staff or person authorized to bind the provider under contract.

PROVIDER IDENTIFICATION NUMBER

Upon DMAS'/FHS' receipt of the signed agreement and upon approval and signature by DMAS/FHS, a provider identification number will be assigned. The provider will be sent a copy of the agreement and the assigned provider identification number. DMAS will not reimburse the provider for any private duty nursing services rendered prior to the assignment of this provider identification number. This number must be used on all billing invoices and correspondence submitted to DMAS. All physical locations must obtain their own separate provider identification number.

PROVIDER PARTICIPATION STANDARDS

In order to be approved for a private duty nursing agreement with DMAS, the provider agency must:

- be licensed or certified as a home health agency by the Virginia Department of Health;
- meet the general requirements stated in this chapter; and
- employ nursing staff meeting the special participation requirements in this chapter.

MEDICAID PROGRAM INFORMATION

Federal regulations governing program operations require Virginia Medicaid to supply program information to all providers. The current system for distributing this information is keyed to the provider number on the enrollment file, which means that each assigned provider receives program information.

A provider may not wish to receive provider manuals or Medicaid memoranda because he or she has access to the publications as part of a group practice. To suppress the receipt of this information, the First Health Provider Enrollment Unit requires the provider to complete the Mail Suppression Form and return it to:

First Health
VMAP-PEU
PO Box 26803
Richmond, Virginia 23261-6803

804-270-5105 or 1-888-829-5373 (in state toll-free), fax – 804-270-7027

Upon receipt of the completed form, FH-PEU will process it and the provider named on the form will no longer receive publications from DMAS. To resume the mailings, a written request sent to the same address is required.

REVIEW OF PROVIDER PARTICIPATION AND RENEWAL OF CONTRACTS

Private duty nursing providers are continually assessed to ensure conformance with Medicaid participation standards and program policies. The provider is assessed on its ability to render consistent, high-quality care to a population in need of nursing home or hospital level of care.

Information used by DMAS to make this assessment includes DMAS' review of documentation submitted by the provider, as well as review of provider files and visits to recipient's homes. The DMAS assessment of the provider is based on a comprehensive evaluation of the provider's overall performance in the following areas:

- Consistency and continuity of care;
- Adherence to the plan of care;
- The plan of care;
- Progress notes;
- Quality of care;
- Health and safety needs of the recipient;
- Billing; and
- Supervisory visits

DMAS will review the provider's performance in all the areas of assessment to determine the provider's ability to achieve high quality of care (i.e., consistency and continuity) and conform to DMAS policies (e.g., supervisory visits, plans of care, etc.). The purposes of this assessment are to determine the frequency and level of review activity which will be conducted by DMAS and to provide feedback to the provider regarding those areas which may need improvement. All providers receive on-site reviews during which the analyst will review recipient files and conduct home visits to assess the quality of care and continued appropriateness of private duty nursing services.

Provider agreements are reviewed and renewed by DMAS every five years. DMAS staff will periodically review provider participation standards and conduct ongoing recipient utilization review.

GENERAL REQUIREMENTS

Providers approved for participation must perform all of the following activities, as well as any others specified by DMAS:

- Immediately notify FH/PEU, in writing, of any change in the information that the provider previously submitted;
- Assure freedom of choice to recipients in seeking medical care from any institution, pharmacy, practitioner, or other provider qualified to perform the service(s) required and participating in the Medicaid Program at the time the service was performed;
- Assure the recipient's freedom to reject medical care and treatment;
- Accept referrals for services only when staff is available to initiate services;
- Comply with Title VI of the Civil Rights Act of 1964, as amended (42 U.S.C. §§ 2000d through 2000d-4a), which requires that no person be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving federal financial assistance on the ground of race, color, or national origin;
- Provide services, goods, and supplies to recipients in full compliance with the requirements of the Rehabilitation Act of 1973, as amended (29 U.S.C. § 794), which states that no otherwise qualified individual with a disability shall, solely by reason of her or his disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving federal financial assistance. The Act requires reasonable accommodations for certain persons with disabilities;
- Provide services and supplies to recipients of the same quality and in the same mode of delivery provided to the general public;
- Charge DMAS for the provision of services and supplies to recipients in amounts not to exceed the provider's usual and customary charges to the general public;
- Accept Medicaid payment from the first day of eligibility;
- Accept as payment in full the amount established by DMAS. 42 CFR § 447.15 requires that a "State Plan must provide that the Medicaid agency must limit participation in the Medicaid Program to providers who accept, as payment in full, the amount paid by the agency." A provider may not bill a recipient for a covered service regardless of whether the provider received payment from the state. A provider may not seek to collect from a Medicaid recipient, or any financially responsible relative or representative of that recipient, any amount that exceeds the established Medicaid allowance for the service rendered.

For example, if a third party payer reimburses $5 of an $8 charge, and Medicaid's allowance is $5, then payment in full of the Medicaid allowance has been made. The provider may not attempt to collect the $3 difference.

The provider may not bill the recipient or DMAS for broken or missed appointments;

- Use program-designated billing forms for submission of charges;

- Maintain and retain business and professional records sufficient to document fully and accurately the nature, scope, and details of the health care provided. Such records shall be maintained in a designated business office from which all private duty nursing provider agency business is conducted.

  In general, such records must be retained for a period of not less than five years from the last date of service or as provided by applicable state laws, whichever period is longer. However, if an audit is initiated within the required retention period, the records must be retained until the audit is completed and every exception resolved. Records of minors must be kept for at least five (5) years after such minor has reached the age of 18 years.

  Policies regarding retention of records shall apply even if the provider discontinues operation. DMAS must be notified in writing of storage, location, and procedures for obtaining records for review should the need arise. The agent or trustee should be located within the Commonwealth of Virginia;

- Furnish to authorized state and federal personnel, in the form and manner requested, access to records and facilities;

- Disclose, as requested by DMAS, all financial, beneficial, ownership, equity, surety, or other interests in any and all firms, corporations, partnerships, associations, business enterprises, joint ventures, agencies, institutions, or other legal entities providing any form of health care services to recipients of Medicaid;

- Hold confidential and use for authorized DMAS purposes only all medical assistance information regarding recipients. A provider shall disclose information in his or her possession only when the information is used in conjunction with a claim for health benefits or the data is necessary for the functioning of DMAS. DMAS shall not disclose medical information to the public;

- Employ and supervise professionally trained staff (meeting the requirements stated in this chapter) to provide private duty nursing services;

- Assure that no processing of bankruptcy or financial insolvency has been adjudicated or is pending in state or federal court and agree to inform DMAS of any action instituted with respect to financial solvency; and

- Have operated as a health care service provider prior to application for Medicaid private duty nursing provider status.

ADHERENCE TO PROVIDER CONTRACT AND SPECIAL PARTICIPATION CONDITIONS

In addition to the above, all providers enrolled in the Virginia Medicaid Program must adhere to the conditions of participation outlined in their individual provider agreements. The paragraphs which follow outline special participation conditions which must be agreed to by private duty nursing providers. A key component of service programs is the continuous monitoring and re-evaluation activity provided by an agency contracted with DMAS to assure efficient and effective service delivery for waiver recipients. For technology assisted waiver and EPSDT private duty nursing recipients, this activity is performed by the Health Care Coordinator within DMAS' Community Based Care (CBC) Unit.

RECIPIENT CHOICE OF PROVIDER AGENCIES

If private duty nursing services are authorized, and there is more than one approved provider agency in the community, the individual will have the option of selecting the provider agency of his or her choice.

NURSING REQUIREMENTS

The private duty nurse must either be a licensed practical nurse (LPN) or a registered nurse (RN) with a current and valid Virginia license. The decision to assign a registered or licensed practical nurse must be based on the needs of the recipient and the nurse's license restrictions. A licensed practical nurse cannot be assigned to perform activities which fall outside the nursing practices allowed and which should be performed by a registered nurse.

RN applicants do not meet the Medicaid requirement of having a valid Virginia nursing license.

In addition, each private duty nurse must demonstrate specialized experience and proficiency with delivery of nursing care to any population which has specialized needs (e.g., a ventilator-dependent individual) prior to assignment to such an individual. It is expected that each nurse will have at least six months of such previous experience as appropriate to the care of the technology assisted waiver/EPSDT private duty nursing recipient. Documentation of the private duty nurse's knowledge, skills, and experience in the care of individuals with special needs and current CPR certification must be included in the nurse's personnel file. This documentation is to be recorded on a skills checklist (DMAS 259) signed by the nurse supervisor prior to the assignment of that nurse to a waiver recipient. This skills checklist may be one developed by the provider (approved by DMAS prior to its use) or the DMAS 259 developed by DMAS (see Appendix B).

For a newly admitted recipient, the orientation and skills checklist (DMAS 259) must be completed by the nursing supervisor for all nurses assigned to the case. When a recipient has been receiving services and a new nurse is assigned, the primary nurse can complete the orientation if he or she is an RN. If the primary nurse is a LPN, then the nursing supervisor is responsible for the orientation.

The nurse providing care cannot be a member of the recipient's immediate family (parent, spouse, child, sibling, grandparent, and grandchild) or legal guardian or have this service already paid for through another source. The nurse providing the care can be an individual who resides in the recipient's home if all of the following criteria are met:

- documentation demonstrates that the provider has tried without success to staff the case with nurses who do not reside with the recipient, and
- the nurse providing the care is not a member of the recipient's immediate family, is not the recipient's legal guardian, and is not being paid for nursing services through another source, and
- the nurse providing the care is employed by a Medicaid-enrolled private duty nursing provider, and
- the recipient is enrolled for services with provider for whom the nursing providing the care is employed.

If the recipient is authorized for more than eight (8) hours per day of nursing services, only eight (8) of the authorized hours per day, up to a maximum of 40 hours per week, may be provided by the live-in private duty nurse.

Note: Documentation in personnel files (e.g., nursing license, CPR, skills checklist [DMAS 259]) must be maintained and available for five (5) years.

SCHEDULING AND SUPERVISION OF NURSING SERVICES

The nursing agency must designate a registered nurse to select and supervise the nursing staff providing direct care. The nursing supervisor is responsible for:

- Assessing the patient's status and needs;
- Reviewing the plan of care for appropriateness and recommending revisions when needed;
- Assuring that the assigned nurses have the necessary licensure and skills to provide safe care (skills checklist [DMAS 259]);
- Evaluating the quality of care provided by the agency nurses and recommending staffing changes where needed;
- Identifying any factors in the home environment that threaten the individual's ability to receive safe and appropriate care; and

- Communicating changes in the patient's status or plan of care to the health care coordinator, case manager, other services providers, family, and DMAS.

SUBSTITUTE NURSING SERVICES

The provider agency is responsible for ensuring that services are provided in accordance with the plan of care. Substitute nurses may be secured from another nursing provider agency for a temporary, short-term period (not to exceed two weeks). The provider agency having case responsibility must ensure that:

- All DMAS requirements continue to be met, including documentation requirements of services rendered and the qualifications of the nurses providing the care;

- Copies of the substitute nurses' licenses, training, and experience, as well as the daily log sheets, are obtained for the individual's record and the agency file;

- Nursing supervision will continue to be provided according to DMAS policies; and

- Services provided by the substitute nurse are billed to DMAS according to policy. (The two provider agencies involved are responsible for determining the financial arrangement for paying the substitute nurses.)

The Health Care Coordinator must be notified any time the provider is unable to staff a waiver service recipient and a qualified substitute nurse cannot be obtained. If another provider can be identified, the case should be transferred to that agency. The Health Care Coordinator must be notified immediately to assist with the transfer.

PROVISION OF NURSING SERVICES OUTSIDE OF THE STATE

In order to provide nursing services to a recipient who is outside of Virginia (e.g., for vacation), the nurse providing care must be licensed in Virginia. The nursing agency may either send a nurse or nurses with the caregiver or contract with an agency in another state as long as that agency has nurses who are licensed in Virginia.

NURSING DOCUMENTATION REQUIREMENTS

Nursing documentation must clearly reflect the recipient's status and needs to enable an ongoing evaluation of the appropriateness of services and provide adequate accountability for all private duty nursing services rendered. The nursing documentation required by DMAS for private duty nursing services consists of the following:

- Daily Nursing Log

  The nursing staff members providing direct care are responsible for recording in a daily nursing log the number of hours of service provided. This information can be recorded on a flow sheet indicating the dates, the time in

and time out, special treatments, medications, vital signs, services by other providers, and pertinent information pertaining to the individual's condition. This verification of time must be signed by a caregiver or other person not employed by the nursing agency.

The nursing provider is required to maintain a full month (based on the number of days in the month) of nursing logs in the recipient's home each month for the Health Care Coordinator to review. Once removed from the home, nursing logs must be retained at the provider agency in an orderly manner which facilitates review by the Health Care Coordinator and DMAS.

- Nursing Status Report

  The nursing supervisor is responsible for completing a home visit at least monthly and more frequently when indicated. The nursing supervisor must submit a report for each month (Nursing Status Report) to the Health Care Coordinator within five (5) working days from the end of the reporting period. A copy of the Nursing Status Report is found in Appendix B. In lieu of the Nursing Status Report, provider agencies may opt to use their own form, provided that the documentation contains all of the following information:

  - Medical Information

    - Dates of physician visits and any change in physician's orders;
    - Hospitalization dates and reasons;
    - Current clinical status;
    - Whether the patient requires the assistance of a medical device, and if so, the type required and the number of hours and days it is required. This does not need to be restated each month, but any change must be noted;
    - Any changes in the recipient's need of nutritional supplements, therapies, etc.; and
    - Whether the patient's needs are being met to ensure his or her health, safety, and welfare.

  - Home Assessment

    - Current home status - any changes in the environment requiring modifications;
    - Family/support and coping abilities (note only any changes);
    - Family and patient response to service and satisfaction with care;
    - Supplies and equipment needed; and
    - Any problems.

  - Contacts with Providers of Health/Social/Education Services

- Indicate the type and date of contacts by other providers and any conflicts and coordination necessary with private duty nursing services.

- Staffing

  - Indicate any change in the nursing staff providing care during the month;
  - Report the total number of hours provided for each month;
  - If hours vary from authorized plan of care, indicate the reason; and
  - Report any respite hours provided by nursing staff.

- Nursing and Respite Care Revision

  The plan of care for private duty nursing is called a Private Duty Nursing Plan of Care form. The original plan of care is developed by the Health Care Coordination Team prior to initiation of services. The type of service to be provided for an individual whose medical needs require nursing care and supervision will not differ whether offered through private duty nursing or respite care.

- OASIS or other required reports

NOTE: All documentation must be maintained and available for at least five (5) years.

CHANGE OF OWNERSHIP

When ownership of the provider agency changes, DMAS must be notified within fifteen (15) calendar days. A new contract, notice of organizational structure, statements of financial solvency and service comparability, and full disclosure of all information required by this chapter relating to ownership and interest will be required.

REQUIREMENTS OF SECTION 504 OF THE REHABILITATION ACT

Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. § 794), provides that no disabled individual shall, solely by reason of the disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving federal assistance. As a condition of participation, each Medicaid provider is responsible for making provision for individuals with disabilities in its program activities.

In the event a discrimination complaint is lodged, DMAS is required to provide to the federal Office of Civil Rights (OCR) any evidence regarding compliance with these requirements.

TERMINATION OF PROVIDER PARTICIPATION

A participating provider may terminate participation in Medicaid at any time; however, written notification must be provided the DMAS Director and FH-PEU thirty (30) days prior to the effective date. The addresses are:

Director
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

First Health
VMAP-PEU
PO Box 26803
Richmond, VA 23261-6803

DMAS may terminate a provider from participating upon thirty (30) days written notification prior to the effective date. Such action precludes further payment by DMAS for services provided to customers subsequent to the date specified in the termination notice.

A copy of this written notification should be sent to the following:

DMAS/Waiver Services Unit
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

RECONSIDERATION AND APPEALS OF ADVERSE ACTIONS

Non-State Operated Provider

The following procedures will be available to all non-state operated providers when DMAS takes adverse action such as termination or suspension of the provider agreement or denial of payment for services rendered based on utilization review decisions.

The reconsideration and appeals process will consist of three phases: a written response and reconsideration to the preliminary findings, the informal conference, and the formal evidentiary hearing. The provider will have 30 days to submit information for written reconsideration and will have a 30 day notice to request the informal conference and/or the formal evidentiary hearing.

An appeal of adverse actions concerning provider reimbursement shall be heard in accordance with the Administrative Process Act (§§ 9-6.14:1 through 9-6.14:25 of the Code of Virginia)(the APA) and the State Plan for Medical Assistance provided for in § 32.1-325 of the Code of Virginia. Court review of final agency determinations concerning provider reimbursement shall be made in accordance with the APA.

Any legal representative of a provider must be duly licensed to practice law in the Commonwealth of Virginia.

State-Operated Provider

The following procedures will be available to state-operated providers when DMAS takes adverse action which includes termination or suspension of the provider agreement and denial of payment for services rendered based on utilization review decisions. State-operated provider means a provider of Medicaid services which is enrolled in the Medicaid program and operated by the Commonwealth of Virginia.

A state-operated provider has the right to request a reconsideration for any issue which would be otherwise administratively appealable under the State Plan by a non-state operated provider. This is the sole procedure available to state-operated providers.

The reconsideration process will consist of three phases: an informal review by the Division Director, DMAS Director review, and Secretarial review. First, the state-operated provider will submit to the appropriate DMAS Division written information specifying the nature of the dispute and the relief sought. This request must be received by DMAS within 30 calendar days after the provider receives its Notice of Amount of Program Reimbursement, notice of proposed action, findings letter, or other DMAS notice giving rise to a dispute. If a reimbursement adjustment is sought, the written information must include the nature of the adjustment sought; the amount of the adjustment sought; and the reasons for seeking the adjustment. The Division Director will review this information, requesting additional information as necessary. If either party so requests, an informal meeting may be arranged to discuss a resolution. Any designee shall then recommend to the Division Director whether relief is appropriate in accordance with applicable law and regulations. The Division Director will consider any recommendation of his or her designee and render a decision.

A state-operated provider may, within 30 days after receiving the informal review decision of the Division Director, request that the DMAS Director or his designee review the decision of the Division Director. The DMAS Director has the authority to take whatever measures he deems appropriate to resolve the dispute.

If the preceding steps do not resolve the dispute to the satisfaction of the state-operated provider, within 30 days after receipt of the decision of the DMAS director, the provider may request the DMAS director to refer the matter to the secretary of health and human resources or any other cabinet secretary as appropriate. Any determination by such secretary or secretaries will be final termination of a provider contract upon conviction of a felony

Subsection (c) of § 32.1-325 of the Code of Virginia mandates that "Any such Medicaid agreement or contract shall terminate upon conviction of the provider of a felony." A provider convicted of a felony in Virginia or in any other of the 50 states must, within 30 days, notify DMAS of this conviction and relinquish the agreement. Reinstatement will be contingent upon provisions of state law.

TERMINATION OF A PROVIDER CONTRACT UPON CONVICTION OF A FELONY

Subsection (c) of § 32.1-325 of the Code of Virginia mandates that "Any such Medicaid agreement or contract shall terminate upon conviction of the provider of a felony." A provider convicted of a felony in Virginia or in any other of the 50 states must, within 30 days, notify DMAS of this conviction and relinquish the agreement. Reinstatement will be contingent upon provisions of state law.

EXHIBITS

DMAS Provider Participation Agreement for Private Duty Nursing

Home and Community-Based Care Application for Provider Status as a Private Duty Nursing Provider

Mailing Suspension Request

DO NOT WRITE IN SHADED AREAS. DO NOT ADD CONDITIONS TO THE AGREEMENT. WE DO NOT ACCEPT AGREEMENTS VIA FAX OR AGREEMENTS ON THERMAL PAPER.

Commonwealth of Virginia
Department of Medical Assistance Services
Medical Assistance Program

Home and Community Based Care Services Participation Agreement
Private Duty Nursing

If re-enrolling, enter Medicaid Provider Number here→ _____ Check this box if requesting new number→ ☐

This is to certify:	PAYMENT/CORRESPONDENCE ADDRESS	PHYSICAL ADDRESS (*REQUIRED IF DIFFERENT FROM PAYMENT ADDRESS*)
NAME		
ATTENTION		
ADDR LINE 1		
ADDR LINE 2		
CITY, STATE, ZIP		

on this _____day of _____ , _____ agrees to participate in the Virginia Medical Assistance Program (VMAP), the Department of Medical Assistance Services, the legally designated State Agency for the administration of Medicaid.

1. **The provider agrees to provide services in accordance with the Provider Participation Standards published periodically by DMAS in the appropriate Provider Manual(s), after being fully certified by DMAS to provide such services. In addition, the provider agrees that all individuals providing services under this Agreement meet the criteria set forth in the above referenced Provider Manual(s).**
2. **Services will be provided without regard to age, sex, race, color, religion, national origin, or type of illness or condition. In accordance with the terms of Section 504 of the Rehabilitation Act of 1973 (29 U.S.C. §794) no handicapped individual shall, solely by reason of his handicap, be excluded from participation in, be denied the benefits of, or be subjected to discrimination in DMAS.**
3. **The provider agrees to keep such records as DMAS determines necessary. The provider will furnish DMAS on request information regarding payments claimed for providing services under the State Plan. Access to records and facilities by authorized DMAS representatives and the Attorney General of Virginia or his authorized representatives, and authorized federal personnel will be permitted upon reasonable request.**
4. **The provider agrees to care for patients at the current rate established by DMAS as of the date of service.**
5. **Payment made under DMAS constitutes full payment on behalf of the recipient except for patient pay amounts determined by DMAS, and the provider agrees not to submit additional charges to the recipient for services covered under DMAS. The collection or receipt of any money, gift, donation or other consideration from or on behalf of a DMAS recipient for any service provided under DMAS is expressly prohibited and may subject the provider to federal or state prosecution.**
6. **The provider agrees to pursue all other health care resources of payment prior to submitting a claim to DMAS.**
7. **Payment by DMAS at its established rates for the services involved shall constitute full payment for the services rendered. Should an audit by authorized state or federal officials result in disallowance of amounts previously paid to the provider by DMAS, the provider shall reimburse DMAS upon demand.**
8. **The provider agrees to comply with all applicable state and federal laws, as well as administrative policies and procedures of DMAS as from time to time amended.**
9. **This agreement may be terminated at will on thirty days' written notice by either party or by DMAS when the provider is no longer eligible to participate in the Program.**
10. **All disputes regarding provider reimbursement and/or termination of this agreement by DMAS for any reason shall be resolved through administrative proceedings conducted at the office of DMAS in Richmond, Virginia. These administrative proceedings and judicial review of such administrative proceedings shall be pursuant to the Virginia Administrative Process Act.**
11. **The provider agrees, at all times, to retain full responsibility for any and all performance under this agreement, whether performed by the provider or others under contract to the provider.**

12. This agreement shall commence on _____ and terminate on _____.

For First Health Services' use *only*

Director, Division of Program Operations Date

IRS Name (required)

mail **one** completed **original** agreement to: **First Health - VMAP-Provider Enrollment Unit**
4461 Cox Rd. Suite 102
Glen Allen, VA 23060-3331

For Provider of Services:

Original Signature of Provider Date

Title

____City or ____County of _____

IRS Identification Number (Area Code) Telephone Number

Medicare Carrier and Vendor Number

HCBC Provider Application
Agency Name _____

HOME AND COMMUNITY-BASED CARE APPLICATION for PROVIDER STATUS as a PRIVATE DUTY NURSING PROVIDER

Name your agency will do business as: _____

PART A. PREVIOUS PROVIDER EXPERIENCE

1. Type of Related Experience:

I request to be approved as a provider of Private duty nursing services. My agency is a home health agency (*not home care organization)* certified by the Virginia Department of Health for Medicaid participation or JCAHO or a daycare center licensed by the Virginia Department of Social Services (*Virginia Administrative Code,* 12VAC30-120-90).

Yes ☐ No ☐ (If "no", your agency cannot be considered for private duty nursing.)

My agency is currently a Virginia Medicaid-enrolled provider of Home Health, Hospital, Rehab, Hospice, Nursing Facility, Clinic or one of the Community-Based Care services.

Yes ☐ No ☐

Type of Provider _____ Provider ID # _____

Type of Provider _____ Provider ID # _____

Type of Provider _____ Provider ID # _____

2. Please type or print the Administrator's Name:

_____

PART B. GENERAL INFORMATION

In accordance with Federal requirements, all providers of Home and Community-Based Care services must submit the following information to the Department of Medical Assistance Services. The information you provide in this section will help us identify information you send to us, and direct where we send critical information you will need as a provider. Please be sure you follow the directions and accurately note the information requested so that we can provide you with quality service.

ADMINISTRATIVE PERSONNEL ***(Fill in all that apply.)***

_____ _____ _____
Person responsible for signing contract Title Phone number

☐ This person is responsible for general management of requested Medicaid program(s)

Reports to:_____

_____ _____ _____
Chief Administrator On-site Title Phone number

☐ This person is responsible for general management of requested Medicaid program(s)

Reports to:_____

_____ _____ _____
Other On-site Contact Person Title Phone number

☐ This person is responsible for general management of requested Medicaid program(s)

Reports to:_____

_____ _____ _____
Chief Corporate Officer Title Phone number

_____ _____ _____
Other Corporate Contact Person Title Phone number

GEOGRAPHICAL AREAS TO BE SERVED ***(See Chapter II for policy re: allowable service area)***

List Cities/Counties in which you intend to serve Medicaid-eligible recipients.

_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____

HCBC Provider Application
Agency Name _____

OWNERSHIP (FILL IN COMPLETELY FOR ALL OWNERS. INCLUDE PERCENT OF OWNERSHIP OF EACH)

LEGAL NAME	ADDRESS	%
_____	_____	_____
_____	_____	_____
_____	_____	_____

OWNER(S) PARTICIPATION IN OTHER FEDERALLY FUNDED PROGRAMS

Federal requirements stipulate that any person listed above in with 5 percent or more ownership of any other Medicaid provider agency or agency that participates in any of the programs established under Title V, XVII, or XX of the Social Security Act must disclose such ownership.

CHECK ONE: _____ N/A _____ APPLICABLE, COMPLETE THIS SECTION

NAME	AGENCY NAME	TYPE OF BUSINESS
_____	_____	_____
_____	_____	_____
_____	_____	_____

TYPE OF AGENCY (PLEASE CHECK ALL THAT APPLY)

Non-Profit	Proprietary	State or Local Government
____ Church Related	____ Single Proprietorship	____ State
____ Non-Profit Corporation	____ Partnership	____ County/City
____ Other Non-Profit Ownership	____ Corporation	____ Hospital (District Authority)
	____ Hospital/Nursing Facility	

CHECK ANY OF THE FOLLOWING SERVICES YOUR AGENCY PROVIDES:

☐ Durable Medical Equipment ☐ Home Health ☐ Social Work Services ☐ Hospice
☐ Rehabilitation Services ☐ Case Management ☐ Others _____

HCBC Provider Application
Agency Name _____

REQUIREMENTS AND SIGNATURE

Any changes which affect the accuracy of the information on this application must be reported promptly to the Community-Based Care Section of the Department of Medical Assistance Services.

Federal requirements stipulate that upon each submission of the provider agreement (or upon actual notice to the provider, whichever is sooner) disclosure of the identity of any person (not limited to but including any owner, operator, manager and/or employee) associated with the agency who has been convicted of a criminal offense (misdemeanor and/or felony) must be made. It is the duty of the provider agency to make inquiry and screen individuals at the point of application for employment to comply with this section.
Has anyone associated with the agency (owner, operators, managers or employees) been convicted of a criminal offense? **Yes ☐ No ☐.**
If yes, explain the type of offense, name and title of individual:_____

_____

The signature below certifies the following:

- That the chief administrative agent understands that in order to comply with Federal regulations, it will not charge DMAS a higher rate for Home and Community-Based Care Services than is charged the private sector for the same services

- That there is neither a judgment nor pending action of insolvency or bankruptcy in a State or Federal Court and that the provider of services agrees to inform the Department of Medical Assistance Services (DMAS) immediately if court proceedings to make a judgment of insolvency or bankruptcy are instituted with respect to the provider of services.

- That the chief administrative agent and professional staff have received and reviewed the program description materials of the Home and Community-Based Care services prior to completing this application.

- That the information within this application is accurate, truthful, and complete.

- That DMAS is authorized to make any contact or inquiries necessary to facilitate completion of the application process.

_____ _____
Print Name of person signing application Print title

_____ _____
Signature of person signing contract Date

PART C. CBC PROGRAM STAFF CREDENTIALS AND REQUIREMENTS

COMPLETE FOR PRIVATE DUTY NURSING

A copy of your Medicare Home Health Agency Certification, JCAHO Certification, or DSS License as a Daycare Center must be attached.

You are responsible for assuring that RN supervisory and private duty nursing staff meet the qualifications detailed in chapter II of the provider manual. All RN's who perform supervisory activities for the private duty nursing program are expected to be knowledgeable of the program eligibility criteria (i.e., Technology Assisted Waiver, AIDS Waiver, MR Waiver) and all program requirements, regardless of whether they perform these activities on a part time basis. It is the provider's responsibility to assure that any new nursing staff who provide services are oriented to the program and have the policy, procedures and forms necessary to comply with DMAS requirements.

1. **List below the person who will be responsible for daily management of the Private Duty Nursing program and who they report to:**

_____ _____ _____
Name Title Phone Number
Reports to: _____ _____
Phone Number

_____ _____ _____
Name Title Phone Number
Reports to: _____ _____
Phone Number

2. **Indicate the number of staff, both full time (FT) and part time (PT) you currently have hired to provide Private Duty Nursing.**

# FT	# PT		# FT	# PT	
___	___	**Registered Nurses**	___	___	**Licensed Practical Nurses**

3. **Complete the following for each RN/LPN who will provide Private Duty Nursing.**

Name	RN/LPN	License #	Expiration Date	Amount/Type Clinical Experience

DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

MAILING SUSPENSION REQUEST

Medicaid Provider Number: _____

Provider Name: _____

I do not wish to receive Medicaid memos, forms or manual updates under the Medicaid provider number given above because the information is available to me under Medicaid provider number

Provider Signature: _____

Date: _____

Please return this completed form to:

First Health Provider Enrollment Unit
P.O. Box 26803
Richmond, VA 23261-6803